Perinatal Hepatitis B Intake Form

Fax to **517-763-0470**; **or call 517-388-4815, 517-897-3236** or **517-242-8319**

Mom's name _____ Date of birth _____ MDSS # _____

Address _____ City _____ Zip _____ County _____

Telephone # _____ Emergency contact name & # _____ Grav _____ Para _____

Race: Asian/PI Black White Amer Indian Alaska Native Other _____ Unknown

Ethnicity: Hispanic Non-Hispanic Unknown Method of Delivery Vaginal Cesarean

Mom's Country of Birth _____ Interpreter Needed Y N If Yes, Language _____

Mom's Insurance Private Medicaid Uninsured County Health Plan Medicare Military (Tricare) Unknown

(P = Positive/Reactive; N = Negative/Non-Reactive; NT = Not Tested; U = Unknown)

HBsAg ___/___/___ P N NT U **Repeat HBsAg** ___/___/___ P N NT U

Date HBsAg Reported ___/___/___ How Reported: Electronic Paper Lab OB Hospital Other _____

HBeAg ___/___/___ P N NT U **HBeAb** ___/___/___ P N NT U

Anti-HBc IgM ___/___/___ P N NT U **Anti-HBc** ___/___/___ P N NT U

HBV DNA ___/___/___ P N NT U **HBV Viral Load** _____ ***Unit* Type** _____

Other Infections/Conditions **(HCV, HIV, Syphilis, Other STIs, etc)** _____

Mom Being Monitored for HBV? Y N U Mom Being Treated for HBV? Y N U

If yes, please indicate: Start Date End Date Reported By

Treatment Type _____ ___/___/___ ___/___/___ ***Mom History*** ***Med Record*** ***Other*** _____

Treatment Type _____ ___/___/___ ___/___/___ ***Mom History*** ***Med Record*** ***Other*** _____

Physician Monitoring/Providing Treatment _____ Telephone # _____

Mom Get Tdap ***(this pregnancy)*** Y N Date ___/___/___ Flu ***(this pregnancy)*** Y N Date ___/___/___ Doses in MCIR Y N

Prenatal Care Provider (PCP) Information:

PCP/Facility Name _____ EDC Date ___/___/___ Telephone # _____

Address _____ City _____ Zip _____

Hospital to Deliver _____ Reporting Information Sent to PCP Y N Date ___/___/___

Household/Sexual Contact Information:

First/Last Name (relationship)	DOB	HBIG	Hep B #1	Hep B #2	Hep B #3	HBsAg, anti-HBs and/or anti-HBc Results	Test Date
	/ /	/ /	/ /	/ /	/ /		/ /
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Contact's Provider Name _____ Address _____

City _____ Zip _____ Telephone # _____

CD Nurse _____ Telephone # _____